Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA HOSPITAL OF DALLAS
4301 VISTA ROAD
PASADENA TEXAS 77504

Respondent Name

SENTRY INSURANCE A MUTUAL CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-05-2357-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated December 14, 2004: "The Carrier did not provide a proper explanations as required by the TWCC Rules and Commission instructions." "The Carrier is allowed to deduct any personal items and may only deduct non-documented services and items and services, which are not related to the compensable injury. At that time, if the total audited charges for *the entire admission* are below $40,000, the Carrier may reimburse at a 'per diem' rate for the hospital services. However, if the total audited charges for *the entire admission* are at or above $40,000, the Carrier shall reimburse using the 'Stop-Loss Reimbursement Factor' (SLRF). The SLRF of 75% is applied to the 'entire admission'." "In this instance, the audited charges that remained in dispute after the last bill review by the insurance carrier were $172,911.61. The prior amounts paid by the carrier were $62,854.07. Therefore, the Carrier is required to reimburse the remainder of the Workers' Compensation Reimbursement Amount of **$73,923.28, plus interest**."

Requestor's Supplemental Position Summary Dated October 27, 2011: "Please allow this letter to serve as a supplemental statement to Vista's originally submitted request for dispute resolution in consideration of the Texas Third Court of Appeal's Final Judgment…The medical records on file with MDR show this admission to be a complex spine surgery which is unusually extensive for at least three reasons…The medical and billing records on file with MDR also show that this admission was unusually costly for two reasons…"

Amount in Dispute: $73,923.28

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated December 13, 2004: "Harris & Harris represents Sentry Insurance in this matter."

Response Submitted by: Harris & Harris on behalf of Sentry Insurance, P.O. Box 162443, Austin, TX 78716

Respondent's Supplemental Position Summary Dated January 3, 2005: "On March 13, 2004, the Claimant underwent in-patient surgery. He remained at HCA Healthcare until March 22, 2003 – without ICU/CCU days. Based on the performed procedure, as well as the length of stay under the Acute Care Inpatient Hospital Fee Guidelines, the requestor invoked the Stop-Loss provision of Commission Rule 134.401 and sought reimbursement of $172,911.61. The surgical procedure performed required the use of implantables. The total amount billed for the implantables was $78,985 leaving a balance of $93,926.61 for the other hospital services. The Carrier reimbursed a total of $62,854.07. The Provider failed to supply the invoices for the implantables with

its HCFA-1500s, hence the Carrier denied reimbursement for those items. It is interesting to note that some such cost invoices have been included with the Provider's MDR filing. Of note, it appears the Provider utilized four Graftech posterior ramps, and billed a total of $32,200. The appears to be a mark-up of 400% over invoice cost." "For the remaining non-implantable charges, 28 T.A.C. §134.401(b)(2)(A) requires a hospital to bill its usual and customary charges for the services provided. The Requestor failed to supply documentation supporting that its charges were, in fact, its usual and customary amount. Also, as the Requestor has failed to document exactly how or why the services it provided were unusually extensive or costly, it is due no further reimbursement." "While the Requestor did bill over $40,000 for its services, it has not shown the procedure to be either unusually costly or extensive. As such, it has failed to meet the two-pronged Stop-Loss criteria, and merits no additional monies."

Response Submitted by: Harris & Harris on behalf of Sentry Insurance, P.O. Box 162443, Austin, TX 78716

The Division confirmed that the current insurance carrier representative is Flahive, Ogden & Latson.

Respondent's Supplemental Position Summary Dated September 12, 2011: "Respondent submits the Respondent's Post-Appeal Supplemental Response as a response to and incorporation of the Third Court of Appeals Mandate in Cause No. 03-07-00682-CV…Based upon Respondent's initial and all supplemental responses, and in accordance with the Division's obligation to adjudicate the payment, in accordance with the Labor Code and Division rules, Requestor has failed to sustain its burden of proving entitlement to the stop-loss exception. The Division must conclude that payment should be awarded in accordance with the general *per diem* payment in accordance with 28 Texas Administrative Code §134.401 (repealed)…"

Response Submitted by: Flahive, Ogden & Latson, 505 West 12th Street, Austin, Texas 78701

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
March 13, 2004 Through March 22, 2004	Inpatient Hospital Services	$73,923.28	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.304, 25 Texas Register 2115, applicable to dates of service on or after July 15, 2000, sets out the procedures for medical payments and denials.
2. Former 28 Texas Administrative Code §133.305, 27 Texas Register 12282, effective January 1, 2003, sets out general provisions for medical dispute resolution.
3. Former 28 Texas Administrative Code §133.307, 27 Texas Register 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
4. Former 28 Texas Administrative Code §134.401, 22 Texas Register 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated April 30, 2004
   - F-Fee guideline MAR reduction.
   - Z560-The charge for this procedure exceeds the fee schedule or usual and customary allowance.

   Explanation of benefits dated May 27, 2004
   - N-Not documented.
   - D-Duplicate charge.
   - Z695-The charges for this hospitalization have been reduced based on the fee schedule.
   - X023-Payment for this charge is not recommended without documentation of cost.
   - U301-This item was previously submitted and reviewed with notification of decision issued to payor/provider (duplicate invoice).
   - Please send complete invoices for all implants.

Explanation of benefits dated June 22, 2004
- M-No MAR.
- G101-Adjusted to usual and customary fees for this type of service

Explanation of benefits dated August 9, 2004
- N-Not documented.
- D-Duplicate charge.
- Z695-The charges for this hospitalization have been reduced based on the fee schedule.
- X023-Payment for this charge is not recommended without documentation of cost.
- U301-This item was previously submitted and reviewed with notification of decision issued to payor/provider (duplicate invoice).
- Please send complete invoices for all implants.

Explanation of benefits dated August 18, 2004
- M-No MAR.
- G101-Adjusted to usual and customary fees for this type of service.

Explanation of benefits dated August 26, 2004
- U301-This item was previously submitted and reviewed with notification of decision issued to payor/provider (duplicate invoice).
- D-Duplicate charge.

Issues

1. Did the respondent provide sufficient explanation for denial of the disputed services?
2. Did the audited charges exceed $40,000.00?
3. Did the admission in dispute involve unusually extensive services?
4. Did the admission in dispute involve unusually costly services?
5. Is the requestor entitled to additional reimbursement?

Findings

Division rule at 28 Texas Administrative Code §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 Texas Register 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Austin's Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." On August 10, 2011, both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The Division received supplemental information from the respondent on September 12, 2011 and then received supplemental information from the requestor on October 27, 2011. The supplemental information was shared among the parties as appropriate. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Austin's Third Court of Appeals' November 13, 2008 opinion, the Division will address whether the total audited charges ***in this case*** exceed $40,000; whether the admission and disputed services in this case are unusually extensive; and whether the admission and disputed services in this case are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection…" 28 Texas Administrative Code §134.401(c) (6) puts forth the requirements to meet those three factors.

1. The requestor in its position statement asserts that "The Carrier did not provide any proper explanations as required by the TWCC Rules and Commission instructions." 28 Texas Administrative Code §133.304(c), 25 Texas Register 2128, effective July 15, 2000, states, in pertinent part, that "At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner

prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s). A generic statement that simply states a conclusion such as 'not sufficiently documented' or other similar phrases with no further description of the reason for the reduction or denial of payment does not satisfy the requirements of this section." Review of the submitted documentation finds that the explanation of benefits dated April 30, 2004, May 27, 2004, June 22, 2004, August 9, 2004, August 18, 2004, and August 26, 2004 were issued using the division-approved form TWCC 62 and noted payment exception codes "F-Fee guideline MAR reduction," "Z560-The charge for this procedure exceeds the fee schedule or usual and customary allowance," "N-Not documented," "D-Duplicate charge," "Z695-The charges for this hospitalization have been reduced based on the fee schedule," "X023-Payment for this charge is not recommended without documentation of cost," "U301-This item was previously submitted and reviewed with notification of decision issued to payor/provider (duplicate invoice)," "M-No MAR," and "G101-Adjusted to usual and customary fees for this type of service". These payment exception codes support an explanation for the reduction of reimbursement based on former 28 Texas Administrative Code §134.401, and therefore support a reduction of the reimbursement amount from the requested stop-loss exception payment reimbursement methodology to the standard per diem methodology amount. The Division finds that the explanation of benefits was sent in the prescribed form and manner and included the correct payment exception codes as required by Division instructions. The Division further finds that the explanation of benefits provided sufficient explanation to allow the provider to understand the reason(s) for the insurance carrier's action(s). The Division therefore concludes that the insurance carrier has met the requirements of §133.304(c).

2. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "…to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold.." Furthermore, (A) (v) of that same section states "…Audited charges are those which remain after a bill review by the insurance carrier has been performed…" Review of the explanation of benefits issued by the carrier on April 30, 2004, May 27, 2004, June 22, 2004, August 9, 2004, August 18, 2004, and August 26, 2004 finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v), therefore the audited charges equal $173,406.61. The Division concludes that the total audited charges exceed $40,000.

3. The requestor in its original position statement stated, in pertinent part "…if the total audited charges for *the entire admission* are at or above $40,000, the Carrier shall reimburse using the 'Stop-Loss Reimbursement Factor' (SLRF). The SLRF of 75% is applied to the 'entire admission'." As noted above, the Austin Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) rendered judgment to the contrary. In its supplemental position statement dated October 27, 2011 the requestor considered the Courts' final judgment and opined on both rule requirements. In regards to whether the services were unusually extensive, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually extensive services. Rule §134.401(c)(2)(C) allows for payment under the stop-loss exception on a case-by-case basis only if the particular case exceeds the stop-loss threshold as described in paragraph (6). Paragraph (6)(A)(ii) states that "This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission." The requestor's supplemental position statement asserts that:

   > "The medical records on file with MDR show this admission to be a complex spine surgery which is unusually extensive for at least three reasons; first, this type of surgery is unusually extensive when compared to all surgeries performed on workers' compensation patients in that only 19% of such surgeries involved operations on the spine; second, this type of surgery requires additional, trained nursing staff and specialized equipment (such as the operating table) thereby making the hospital services unusually extensive; and third, the median length of stay ("LOS") for workers' compensation inpatient admission is three days whereas the length of stay for this admission exceeds the median LOS. Finally, any evidence of comorbidities, which should be considered, is part of the medical records, which have been previously filed."

   The requestor's categorization of spinal surgeries presupposes that all spinal surgeries are unusually extensive for the specified reasons. The requestor did not submit documentation to support the reasons asserted, nor did the requestor point to any sources for the information presented. The reasons stated are therefore not demonstrated. Additionally, the requestor's position that all spinal surgeries are unusually extensive does not satisfy §134.401(c)(2)(C) which requires application of the stop-loss exception on a case-by-case basis. The Third Court of Appeals' November 13, 2008 opinion affirmed this, stating "The rule further states that independent reimbursement under the Stop-Loss Exception will be 'allowed on a case-by-case basis.' *Id.* §134.401(c)(2)(C). This language suggests that the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases." The requestors position that all spine surgeries are unusually

extensive fails to meet the requirements of §134.401(c)(2)(C) because the particulars of the services in dispute are not discussed, nor does the requestor demonstrate how the services in dispute were unusually extensive in relation to similar spinal surgery services or admissions. For the reasons stated, the Division finds that the requestor failed to demonstrate that the admission and services in dispute are unusually extensive.

4. In regards to whether the services were unusually costly, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services. 28 Texas Administrative Code §134.401(c)(6) states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor's supplemental position statement asserts that:

   > "The medical and billing records on file with MDR also show that this admission was unusually costly for two reasons: first the median charge for all workers' compensation inpatient surgeries is $23,187; the median charge for workers' compensation surgeries of this type is $39,000; therefore the audited billed charges for this surgery substantially exceed not only the median charges, but also the $40,000 stop-loss threshold; second, as mentioned in the preceding paragraph, in order for this surgery to be performed, specialized equipment and specially trained, extra nursing staff were required, thereby adding substantially to the cost of surgery in comparison to other types of surgeries."

   The requestor asserts that because the ***billed charges*** exceed the stop-loss threshold, the admission in this case is unusually costly. The Division notes that audited charges are addressed as a separate and distinct factor described in 28 Texas Administrative Code §134.401(c)(6)(A)(i). Billed charges for services do not represent the cost of providing those services, and no such relation has been established in the instant case. The requestor fails to demonstrate that the ***costs*** associated with the services in dispute are unusual when compared to similar spinal surgery services or admissions. For that reason, the division rejects the requestor's position that the admission is unusually costly based on the mere fact that the billed or audited charges "substantially" exceed $40,000. The requestor additionally asserts that certain resources that are used for the types of surgeries associated with the admission in dispute (i.e. specialized equipment and specially-trained, extra nursing staff) added substantially to the cost of the admission. The requestor does not list or quantify the costs associated with these unusual resources in relation to the disputed services, nor does the requestor provide documentation to support a reasonable comparison between the resources required for both types of surgeries, and therefore fails to demonstrate that the resources used in this particular admission are unusually costly when compared to resources used in "other types of surgeries." As noted above, the Third Court of Appeals' November 13, 2008 opinion stated that "…the Stop-Loss Exception was meant to apply on a case-by-case basis in a relatively few cases." The Division concludes that the requestor failed to demonstrate that the specific services in this dispute were unusually costly when compared to similar spinal surgery services or admissions.

5. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, 28 Texas Administrative Code §134.401(c) (1) applies. Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of $1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "(ii) The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission…" Review of the discharge summary finds that the injured worker was admitted on March 14, 2004 and discharged on March 22, 2004. The length of stay is therefore 8 days. The surgical per diem rate of $1,118 multiplied by the length of stay of 8 days results in an allowable amount of $8,944.00.

   28 Texas Administrative Code §134.401(c)(4), states "Additional reimbursement. All items listed in this paragraph shall be reimbursed in additional to the normal per diem based reimbursement system in accordance with the guidelines established by this section. Additional reimbursement apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section."

   28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)."

   A review of the submitted medical bill indicates that the requestor billed revenue code 278 for Implants at $78,988.00. Based upon the submitted explanation of benefits, the respondent paid $11,845.20 based upon "M-No MAR."

   Based upon the submitted invoice and itemized statement the Division finds the total allowable for the implants billed under revenue code 278 is:

Description of Implant per Itemized Statement	Quantity	Cost Invoice	Cost + 10%
Grafton Flex 5 cm X 5cm 522150	2	No support for cost/ invoice	$0.00
Graftech Posterior Ramp 13 mm 68522	2	$2025.00/each	$2025.00 + $202.50 = $2,227.50 X 2 = $4,455.00
Graftech Posterior Ramp 9 mm 985221	2	$2025.00/each	$2025.00 + $202.50 = $2,227.50 X 2 = $4,455.00
Floseal 5 cc 934056	2	No support for cost/ invoice	$0.00
Screw Pedicle 6.5 X 45 mm SG6545	1	No support for cost/ invoice	$0.00
Screw Pedicle 6.0 x 40mm SG6040	4	No support for cost/ invoice	$0.00
Rod 6 x 70mm SG1607	1	No support for cost/ invoice	$0.00
Rod 60mm Spinal Solution SG1606	1	No support for cost/ invoice	$0.00
Screw Caps SG3010	5	No support for cost/ invoice	$0.00
Connectors 1 mm SG3601	3	No support for cost/ invoice	$0.00
TOTAL DUE			$8,910.00

Therefore, the total allowable due for this admission per 28 Texas Administrative Code §134.401(c) (1) is $17,854.00 ($8,944.00 + $8,910.00). Review of the submitted documentation finds that the respondent issued payment in the amount of $62,854.07 for the inpatient hospitalization. Additional reimbursement can not be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed $40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually costly services, and failed to demonstrate that the services in dispute were unusually extensive. The requestor further failed to establish that additional payment is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	2/23/2012 Date
Signature	Medical Fee Dispute Resolution Manager	2/23/2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.